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14. ABSTRACT The Master Resilience Training (MRT) Medical Program includes a 2-hour Resilience Training for Healthcare Staff (RTHS) aimed to bolster resilience by preventing compassion fatigue and burnout. As per Army Operation Order (OPORD) 14-43, the training is required by Soldiers and Department of the Army (DA) Civilians working at Army Military Treatment Facilities (MTFs). Since its implementation in August 2014, MTF compliance with offering the RTHS training had not been evaluated. As of September 2016, 149 MRTs had been certified to teach the MRT Medical Program. Between October and November 2016, 149 MRTs received an online survey invitation. A follow up phone survey was attempted to 97 MRTs stationed INCONUS. Results of the evaluation included confirming the number of MRTs certified to teach the RTHS module, percentages of MTF Commands that offer RTHS, and barriers to offering RTHS at MTFs. Recommendations to system, policy, and program barriers can improve compliance with the OPORD 14-43. Future steps include an outcomes evaluation, and an implementation fidelity evaluation of the RTHS module.					
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1. **BACKGROUND:** Based on the Care Provider Support Program (CPSP), the Army Medical Department Center and School (AMEDDC&S) and the Walter Reed Army Institute of Research (WRAIR) Research Transition Office (RTO) developed the Master Resilience Training (MRT) - Medical Program, which consists of a 3-day MRT-Medical Workshop and a two-hour Resilience Training for Healthcare Staff (RTHS) module.
 - a. **MRT Medical Workshop:** The purpose of the 3-day workshop is to certify Master Resilience Trainers (MRTs) at military treatment facilities (MTFs) to teach the MRT-Medical Program. MRTs learn medical examples for the general MRT skills as well as the 2-hour RTHS module.
 - b. **RTHS:** The purpose of this 2-hour module is to bolster resilience by preventing compassion fatigue and burnout. As per Operation Order (OPORD) 14-43, RTHS is a triennial requirement for all Soldiers and Department of the Army (DA) Civilians working at MTFs.
2. **PURPOSE:** To detail findings and recommendations from phase 1 of the RTHS implementation evaluation. The purpose of phase 1 ("compliance") was to assess whether MTFs were teaching RTHS and to identify implementation barriers and strategies for overcoming those barriers.
3. **DATA COLLECTION:** Phase 1 data collection was completed OCT through NOV 2016.
 - a. **Target Population:** The target population for this data collection was all RTHS-certified MRTs. As per OPORD 14-43, a projected minimum of 250 (i.e., 50% of MTF MRTs) should have been certified to teach the MRT Medical Program, including RTHS, by FEB 2015. As of SEP 2016, 149 MRTs had been certified to teach the MRT Medical Program.
 - b. **Survey Distribution:** An online survey was distributed via email to the population of RTHS-certified MRTs (N = 149). One month after the initial survey invitation, a phone survey was attempted for RTHS-certified MRTs with duty station INCONUS who had not completed the online survey and for whom a valid phone number was available (n = 97).
 - c. **Survey Content:** Three key questions were included in both the online and phone surveys: (1) In the past year, did your MTF offer RTHS?; (2) Do you think RTHS is relevant for healthcare staff?; and (3) What are the barriers to delivering RTHS? How can we overcome those barriers? The online survey was more comprehensive than the phone survey, including additional questions about RTHS as well as the MRT Medical Workshop and the medical examples for the general MRT skills.
 - d. **Response Rates:** Thirty-nine (26%) RTHS-certified MRTs completed the online survey, and 42 (28%) completed the phone survey. Twelve (8%) RTHS-certified MRTs completed both the online and the phone surveys, resulting in a total of 69 (46%) unique responses to the three key program evaluation questions included in both surveys.
 - e. **Characteristics of Respondents:** Respondents (N = 69) were 62 Soldiers (including 1 retired) and 7 DA Civilians. Ten of the 62 Soldiers (16%) were officers (primarily O-3), and 52 (84%) were enlisted (primarily E-7). Table 1 shows the ranks of the respondents that completed the online or phone surveys. Three-quarters of the respondents were enlisted Soldiers.

Table 1. Ranks of the 69 respondents who completed either the online or phone survey.

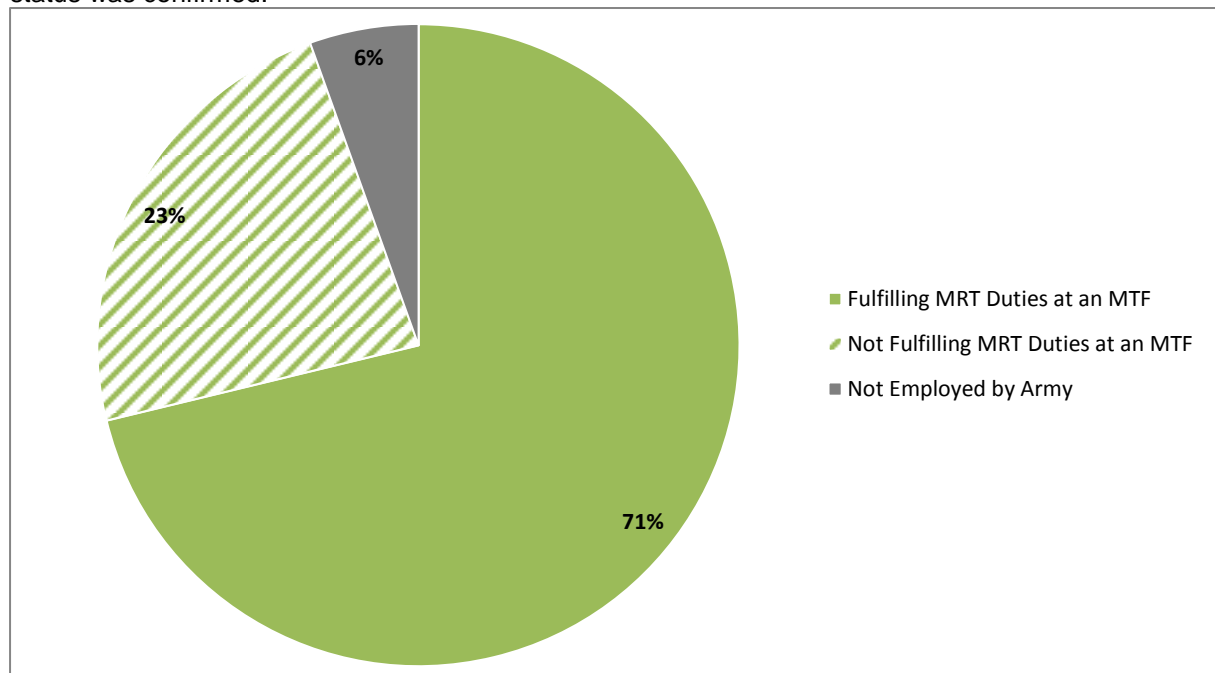
Rank	Count
Enlisted	52
SGT (E-5)	1
SSG (E-6)	13
SFC (E-7)	29
MSG (E-8)	7
1SG (E-8)	2
Officer	10
1LT (O-2)	1
CPT (O-3)	7
MAJ (O-4)	1
LTC (O-5)	1
DA Civilian	7

4. FINDINGS:

a. Availability of RTHS-Certified MRTs

- i. The status of 73 (49%) RTHS-certified MRTs was confirmed; 71% of these MRTs were fulfilling MRT duties at MTFs and was available to teach RTHS. Figure 1 shows the availability of RTHS-certified Master Resilience Trainers (MRTs) among 73 MRTs whose status was confirmed. Seventy-one percent (n = 52) of these MRTs were fulfilling MRT duties at an MTF (i.e., available to teach RTHS to healthcare staff).

Figure 1. Availability of RTHS-certified Master Resilience Trainers (MRTs) among 73 MRTs whose status was confirmed.



- ii. The status of the remaining 76 (51%) RTHS-certified MRTs was unconfirmed; these MRTs were unresponsive to survey emails and phone calls.

b. MTFs

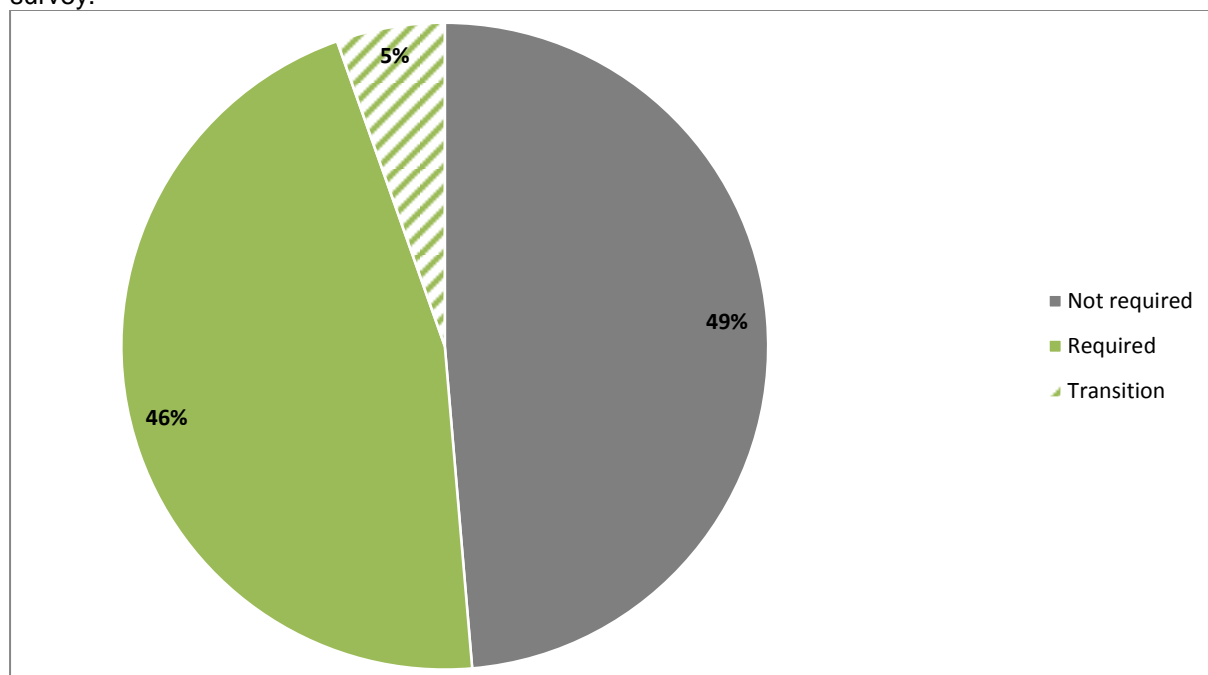
- i. Twenty-four installations had at least one RTHS-certified MRT who was fulfilling MRT duties at an MTF (i.e., available to teach RTHS).
- ii. The average MTF had 963 Soldiers and DA Civilians (range: 13 to 4,900) and 2 RTHS-certified MRTs (range: 1 to 7).
 1. Given the interactive nature of RTHS, AMEDD C&S and WRAIR recommend a class size of 30 to 50.
 2. Assuming a class size no larger than 50, the average MTF, with approximately 1,000 staff who are required to complete RTHS every three years, would need to offer the course a minimum of 7 times every year for all staff to be trained.

c. RTHS

i. RTHS Instruction at MTFs

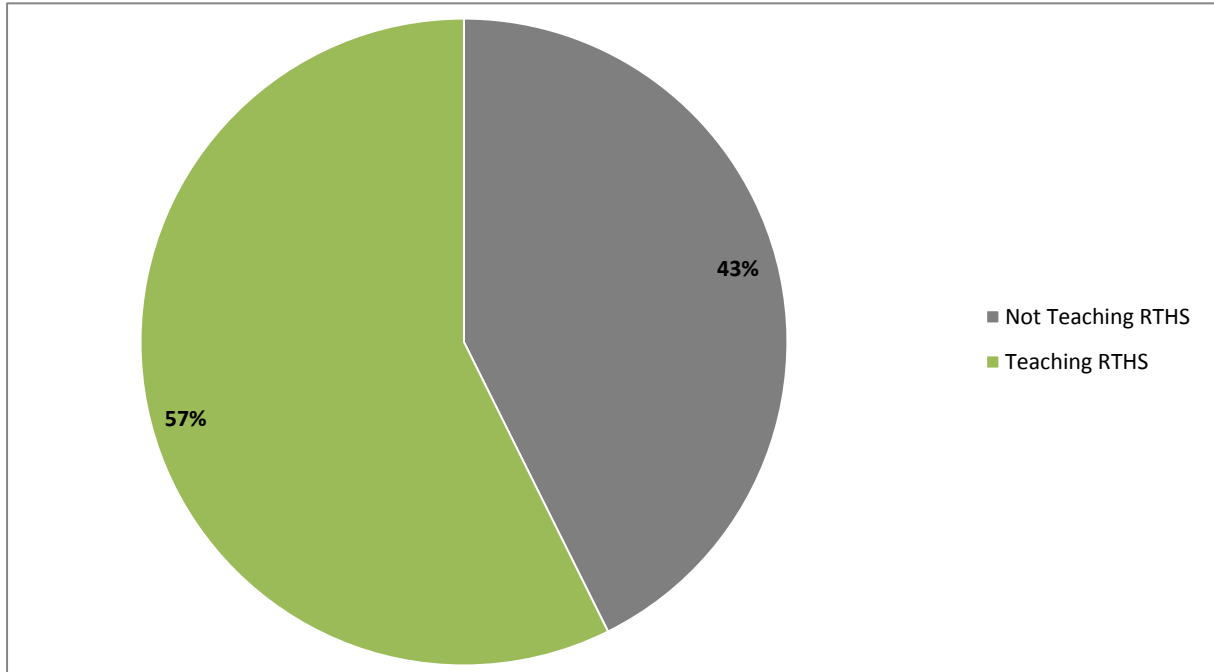
1. 46% of MRTs reported their MTF Commanders require the RTHS module, as shown in Figure 2. 5% of MRTs reported their Commanders were in the process of establishing the module as a requirement at the MTF ("Transition").

Figure 2. MRTs reporting their MTF Commanders require the RTHS module. *Data source:* online survey.



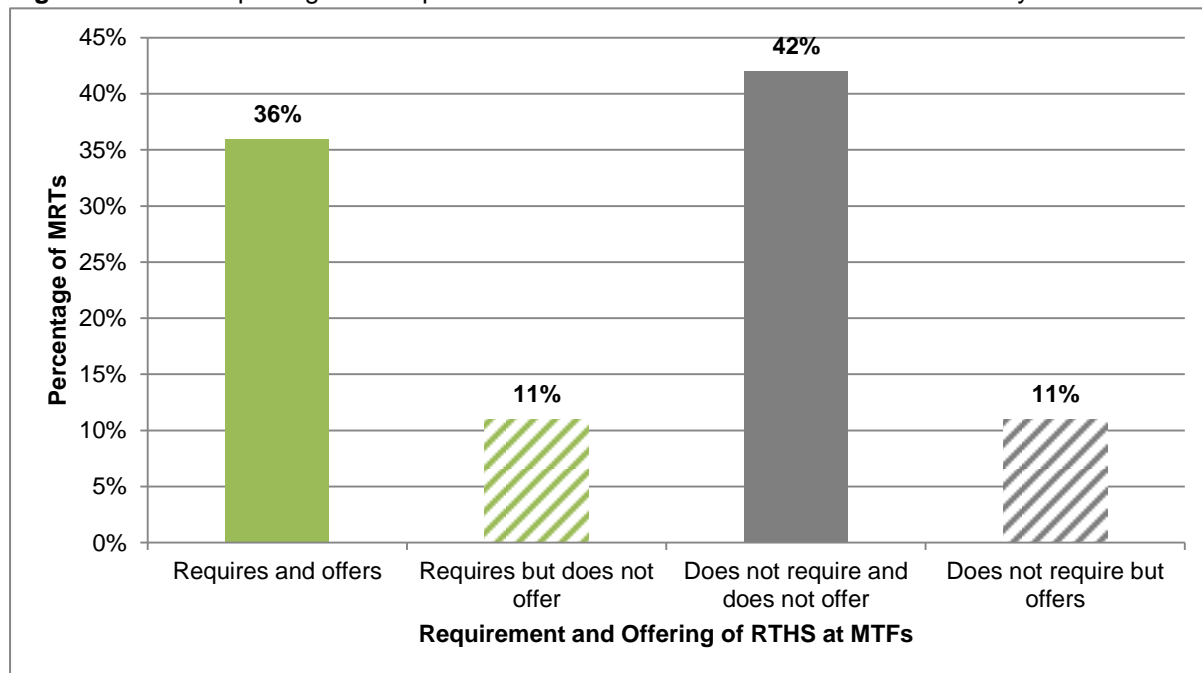
2. 57% of MRTs reported their MTFs had taught the RTHS module at least once in the past year, shown in Figure 3.

Figure 3. MRTs reporting their MTFs taught RTHS in the past year. *Data source:* online and phone



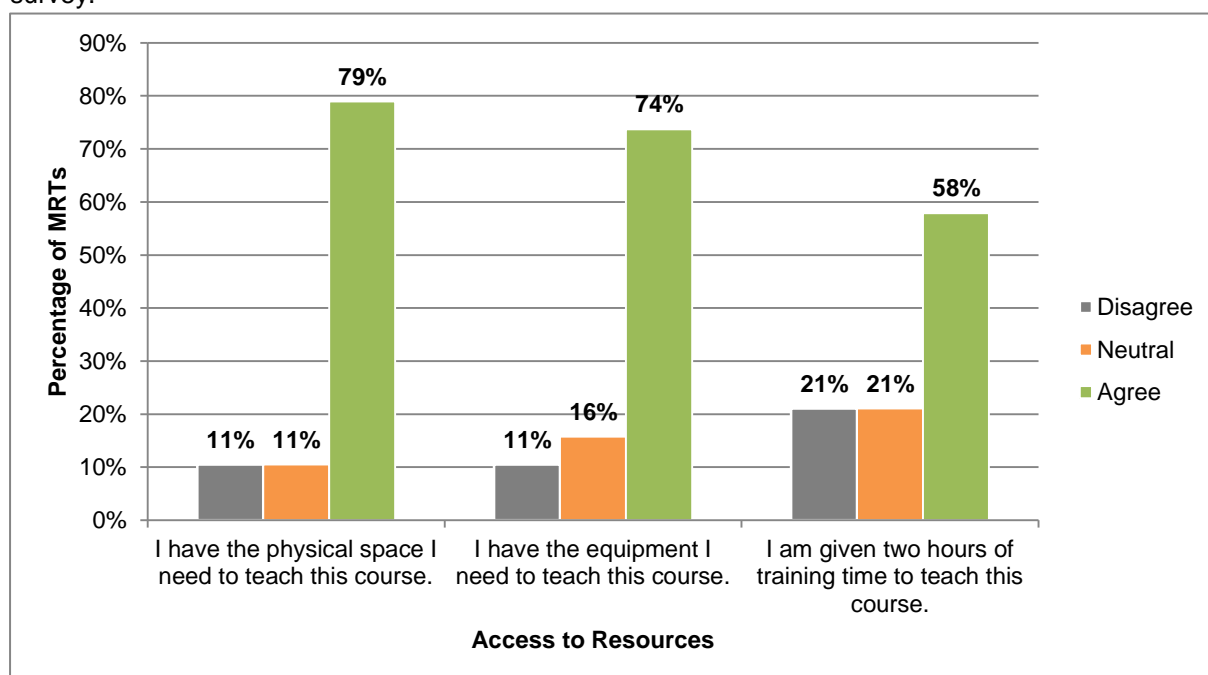
3. However, based on an average class size of 50, only 41% of MTFs had offered the course frequently enough to get all healthcare staff trained in three years.
4. The discrepancy between the number of MRTs reporting their Commanders *require* RTHS and their MTFs *teach* RTHS may be best explained by (1) the differences in sample size (i.e., the requirement data was pulled from the online survey [$n = 39$], whereas the teaching data was pulled from both the online and phone surveys [$N = 69$]) and (2) the imperfect correlation between an MTF requiring and teaching the module:
 - a. 11% of MRTs reported that though their MTF required RTHS, it had not been taught in the past year
 - b. 11% of MRTs reported that though their MTF did not require RTHS, it had been taught anyway in the past year, as shown in Figure 4.

Figure 4. MRTs reporting MTF requires and offers RTHS. *Data source:* online survey.



5. Attendance at an average RTHS session was 19 Soldiers and 11 DA Civilians.
6. Among MRTs whose MTFs were teaching RTHS, the greatest resource barrier was time (i.e., having a full two-hour training block to teach the course), as shown in Figure 5. Only 58% of MRTs reported they had a full two-hour training block to teach the course.

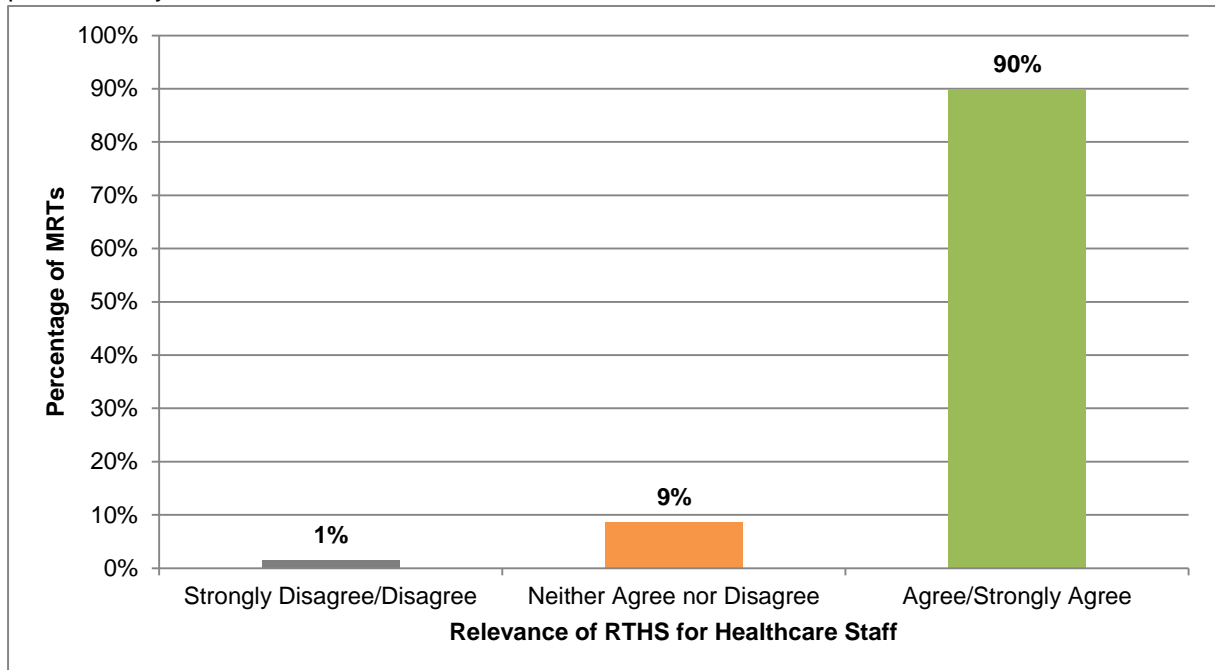
Figure 5. Access to barriers among MRTs whose MTFs are teaching RTHS. *Data source:* online survey.



ii. Perceptions of RTHS

1. 90% of MRTs believe RTHS is a useful and relevant module for healthcare staff, as shown in Figure 6.

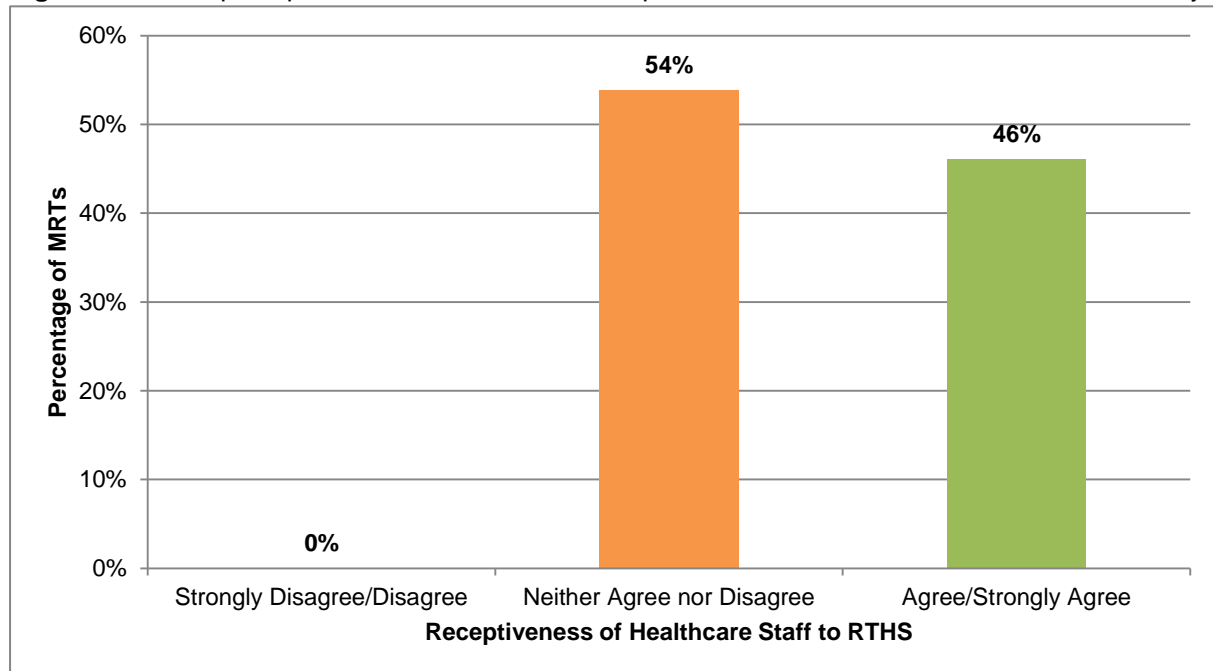
Figure 6. MRTs' perception of the relevance of RTHS for healthcare staff. *Data source:* online and phone survey.



a. Sample Qualitative Comments:

- i. "I use MRT skills and [RTHS] skills with most every patient encounter."
 - ii. "This was the best training I ever did in the military; [it] influenced me to become a psychologist."
2. 46% of MRTs believe healthcare staff are receptive to RTHS, as shown in Figure 7.

Figure 7. MRTs' perception of healthcare staff's receptiveness to RTHS. *Data source:* online survey.



a. *Sample Qualitative Comments:*

- i. "I have had several personnel, after receiving the course, tell me how appreciative they are for the material."

d. Barriers

- i. The following list of system, policy, and program barriers is derived from common themes identified in the qualitative data from both the online and phone surveys.

ii. System Barriers

1. *No tracking systems:* No systems currently exist for tracking healthcare staff completion of the RTHS training requirement or for tracking RTHS-certified MRTs as they change roles, change duty stations, or leave the military.
2. *No ownership of the program:* No entity has taken ownership of the implementation of the program. MTFs have not been held accountable for offering RTHS, nor have healthcare staff been held accountable for completing RTHS.

iii. Policy Barriers

1. *Lack of clarity in the OPORD:* Confusion persists regarding the nature of the requirement.
 - a. Only 46% of MRTs reported their MTF Commander requires the module (quantitative data), and some Regional Health Commands have prohibited MRTs from teaching RTHS.
 - b. The guidelines outlined in OPORD 14-43 are unclear, broadly requiring "a MRT-MED training provided by MTF MRTs" (see FRAGO 2, paragraph 3.6). For example, an MTF could require Soldiers and DA Civilians to attend a 30-minute, Hunt the Good Stuff lesson; by mentioning burnout and/or compassion fatigue and/or using the medical examples for this skill, the MTF

would have satisfied the “MRT-MED” training requirement as it is currently written in the OPORD.

2. *Limited sustainability of the program:* Many MTFs have inadequate manpower to deliver RTHS, particularly when all staff had to be trained every year.
 - a. This is likely the result of not certifying enough MRTs to meet the need and not backfilling positions as MRTs PCS or ETS.
 - i. As per OPORD 14-43, at least 250 MRTs should have certified to teach RTHS by FEB 2015; however, only 149 had been trained as of SEP 2016.
 - b. This burden was likely reduced by FY17 training guidance from MEDCOM, which reduced the frequency of all trainings to every three years; however, it is likely that most MTFs still have inadequate manpower to train all healthcare staff.

iv. Program Barriers

1. *Low buy-in:* Leaders and healthcare staff do not understand the need for resilience training or the impact of compassion fatigue and burnout; furthermore, they prioritize patient care over staff/self-care.
2. *Confusion about MRT:* Negative connotations surrounding the general MRT course negatively impact the perception of the RTHS module (colloquially referred to as “MRT-Med”); leaders and healthcare staff do not understand the difference in scope between the general MRT course and the MRT-Medical Program. Additionally, MRT concepts integrated into RTHS are confusing for DA Civilians, who are not required to complete the general MRT course.
3. *Suitability of the audience:* There continues to be disagreement about who should and should not be required to complete RTHS.
 - a. One group of MRTs believed the course should be required for all healthcare staff in both MEDCOM and FORSCOM units.
 - b. Another group of MRTs believed the course should only be required for healthcare providers who are consistently exposed to trauma and would, therefore, be at higher risk for compassion fatigue.
 - c. Finally, another group of MRTs believed the burnout component of the course should be required for all Soldiers in the Army.

5. RECOMMENDATIONS:

a. System Recommendations

- i. **Program manager:** Establish a program manager (PM) within the Move to Health program (under the System for Health division under the OTSG Deputy Chief of Staff for Public Health) who would oversee the implementation of RTHS. The PM would serve as the point of contact for all issues related to RTHS policies and implementation.
- ii. **System for tracking training requirement for healthcare staff:** List RTHS in the Digital Training Management System (DTMS) as a required training for all healthcare staff (Soldiers and DA Civilians) at MTFs.
- iii. **System for tracking RTHS-certified MRTs:** List the MRT-Medical Workshop in the Digital Training Management System (DTMS) as an optional training for MRTs.

1. The training non-commissioned officer (NCO) at each installation has access to DTMS and would be able to track which MRTs at the MTF were certified to teach RTHS.
2. Although this system will allow MTFs to identify how many RTHS-certified MRTs are stationed at the facility, this system will not clarify whether each MRT is actively fulfilling MRT duties and, thus, available to teach RTHS. The PM may need to develop and implement a supplemental system for tracking MRTs' availability.

b. Policy Recommendations

- i. **Required RTHS-certified MRT to staff ratio (1:450):** Require a minimum MRT to staff ratio in the OPORD to help ensure MRTs are not overburdened by the course and to help ensure each MTF is properly powered.
 1. Assuming an MTF of 450 healthcare staff and one RTHS-certified MRT:
 - a. 450 healthcare staff would need to complete RTHS every three years; thus, approximately 150 healthcare staff would need to complete RTHS every year.
 - b. With a class size of 30 to 50, an MRT would need to teach RTHS 3 to 5 times every year to be able to train 150 staff members in one year and all 450 staff members in three years.
 2. Teaching RTHS is an additional duty beyond teaching the 12 required MRT skills, all of which is in addition to regular staffing duties, so the requirement of providing the class 3 to 5 times a year seems like a manageable workload addition.
- ii. **Continuing education units (CEUs) for course completion:** Offer CEUs for course completion to improve buy-in, particularly for providers who are required to complete a certain number of CEUs annually.
 1. For example, the Center for Deployment Psychology (CDP) currently offers a similar course, entitled "Provider Resilience and Self-Care", for 1 CEU.
- iii. **FRAGO to OPORD 14-43:** Develop and disseminate a third FRAGO to OPORD 14-43.
 1. The OPORD should clearly delineate the requirement as well as the supporting processes:
 - a. Specify which training is required (e.g., the two-hour, Resilience Training for Healthcare Staff module).
 - b. Specify a suspense for healthcare staff to be initially trained; three years from the issuance of the OPORD should give MTFs ample time to have MRTs certified to teach RTHS and to then deliver the module to their staff.
 - c. Specify the required MRT to staff ratio (e.g., 1:450).
 - d. Specify who is required to take the course; clarify what an MTF is and whether the course is required for all healthcare staff (including administrative staff) or only healthcare providers.
 - e. Specify the required length of training (e.g., two hours).
 - f. Specify the role of the program manager and how to contact the program manager for implementation support.

- g. Specify the tracking systems that will be used to track healthcare staff's fulfillment of the training requirement and MRTs' availability to teach the course.

c. Program Recommendations

- i. **Separate program from MRT:** Rebrand the course, moving away from MRT, and modify or drop day 2 of the Workshop.
 1. Identify a new name for the MRT Medical Program, including the workshop and RTHS, that is not connected to MRT and that will better resonate with healthcare staff.
 2. Remove MRT concepts and language from the MRT Medical Program, including the workshop and RTHS.
 3. As the program moves away from MRT, the medical examples of the general MRT skills should be turned over to the Army Resiliency Directorate (ARD). Thus, day 2 of the workshop, which deals almost entirely with the MRT skills, should be modified or dropped.
 - a. Modifying Day 2 would allow more discussion about the key course concepts and would also give MRTs more time to practice the delivery of the module, which could help ensure the module is being taught to standard at each MTF.
 - b. Dropping Day 2 could improve buy-in from MTF Commanders, as their MRTs' involvement in the workshop would be less expensive and less time consuming (one fewer day on temporary duty [TDY]); this would also allow AMEDD C&S to offer more workshops, which will be needed to train the required number of MRTs.
- ii. **Allow non-MRTs to be certified to teach RTHS:** Allow non-MRT Soldiers and DA Civilians to be certified to teach RTHS.
 1. As the course moves away from MRT, there will no longer be a need for trainers to be certified MRTs.
 2. Consider utilizing more DA Civilians due to longer time at the MTFs.
 - a. On average, Soldiers were stationed at their MTFs approximately 4 years, whereas DA Civilians spent an average of at least 6 years at their MTFs.
 - b. Because DA Civilians seem to be staying at their facilities for longer periods of time, using more DA Civilians to teach the course may help reduce the frequency of turnover.
- iii. **Split course into two 1-hour modules:** Split the 2-hour RTHS module into two 1-hour modules: one module to address compassion fatigue and one module to address burnout.
 1. Compared to a 2-hour module, a 1-hour module is better suited for current training schedules.
 2. The 1-hour burnout module could also be listed on the menu of optional trainings currently being compiled by ARD.

6. NEXT STEPS:

- a. Two additional evaluations can occur:
 - i. A “fidelity” implementation evaluation can identify whether RTHS-certified MRTs are teaching the course to standard.
 - ii. An outcomes evaluation can identify if RTHS benefits healthcare staff.
 - 1. The outcomes evaluation will compare three intervention conditions: (1) a 2-hour compassion fatigue and burnout module (i.e., the full RTHS module), (2) a 1-hour burnout module (i.e., a condensed RTHS module), and (3) a survey-only control. Key outcomes that will be assessed include (1) self-assessment and self-care knowledge and behaviors, (2) compassion fatigue, (3) burnout, (4) depression, (5) sleep, and (6) suicide risk.
- b. WRAIR recommends beginning with the outcomes evaluation in order to determine the best course of action (COA) for further implementation of this program, following with the fidelity implementation after that new COA is established. WRAIR will await guidance from OTSG Deputy Chief of Staff (DCoS) for Public Health on next steps.

7. **POINT OF CONTACT:** For further information, please contact Dr. Amanda Start at WRAIR RTO (301-319-9701; amanda.r.start.ctr@mail.mil).

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